



# Assignment of Benefits

I hereby assign all medical benefits to which I am entitled, including Medicare and Medicaid, private insurance, and any other health plan to:

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This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid and original. I recognize and accept responsibility for payment of services rendered regardless of the insurance coverage.

**SIGNATURE**

**DATE**

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**NAME**

**RELATIONSHIP TO PATIENT**

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Your signature below indicates that you have read and understand this Agreement and agree to their terms.

**SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE**

**DATE**

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**PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE**

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